EXHIBIT 3

POLICE DEPARTMENT, COUNTY OF SUFFOLK, N.Y.

PISTOL LICENSING BUREAU / RELEASE OF MEDICAL RECORDS

PDCS-4409-1

I, , [redacted] LAMARCO D.O.B., [redacted] Social Security Number, [redacted]
residing at [redacted] PT JEFFERSON STATION, NY 11776, do hereby authorize any member, or representative, of the Suffolk County Police Department to seek the release of information contained in all of my records maintained by your office at:

Name of Medical Provider _ CATHOLIC CHARITIES
Address _ 1727 N OCEAN AVE 631-654-1919
_ MEDFORD NY 11763

Further, I hereby authorize your office to release said medical information to any member, or representative, of the Suffolk County Police Department.

The following requested information is necessary in order for the Suffolk County Police Department to complete an investigation to determine the fitness of the above individual to reside in a home with firearms.

Please provide a letter containing the following information:

1. **Reason for treatment;**
2. **List of any medications prescribed, and its effect(s) - possible side effects - on patient;**
3. **Your professional opinion as to the competence of the patient to reside in a home with firearms.**

Please forward the above requested letter to the following;

Suffolk County Police Department
Pistol Licensing Bureau
30 Yaphank Avenue
Yaphank, New York 11980

The requested information is to be forwarded to the Suffolk County Police Department at my request, and will be used by the Suffolk County Police Department for investigative purposes. I am aware that the information disclosed pursuant to this Authorization may be subject to redisclosure and would no longer be protected.

The expiration of this authorization is two years from the date of my signature.

I understand I have the right to revoke this authorization by forwarding written notice to the Suffolk County Police Department or the medical provider specified above. I am aware also that any revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

I understand I do not have to sign this authorization, and my refusal to sign will not affect my abilities to obtain medical treatment, nor will it affect my eligibility for any benefits. However, I understand that failure to sign this authorization, or revocation of this authorization, will affect my eligibility to possess a pistol license. I further understand I have a right to inspect and copy my protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found in 45 CFR Section 164.524).

I understand this authorization will include information related to (check if applicable and initial):

- ☑ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection (patient initials) [redacted]
- ☑ Behavioral health services / psychiatric care (patient initials)
- ☑ Treatment for alcohol and/or drug abuse (patient initials)

I understand that I am protected by the law from HIV related discrimination in housing, employment, health care and other services. For more information, I may contact the NYS Division of Human Rights Office of AIDS Discrimination issues at **1-800-523-2437 or (212) 480-2522**, or the New York City Commission of Human Rights at **(212) 306-7500**; these agencies are responsible for protecting my rights.

- OVER -

I authorize the use of my health information as set forth in this document.

[redacted]

Signature of Patient

Dated 5/15/21

[redacted]

Name of Patient (Printed) [redacted] LA MARCO

Date of Birth [redacted]

Sworn to before me on May 15, 2021

Witnessed by: Richard Fuentes

Notary Public

THOMAS P. LA MARCO
Notary Public, State of New York
No. 52-7407750
Qualified in Suffolk County
Commission Expires May 31, 2022

POLICE DEPARTMENT COUNTY OF SUFFOLK, N,Y. C.C.#
STATEMENT FORM
PDCS-1165b
Date 6/3/21 Time 9:40 AM
Page 1 of 2

I, **Diane E LAMARCO of** [redacted] **PT JEFF STATION, NY 11776 Lic #C-**[redacted] (being duly sworn) deposes and says:

name

(words "being duly sworn" are to be crossed out if a sworn statement is not being prepared) that I am 60 years old.

(age)

I was born on [redacted] I am giving this statement to Officer Plitcik.

d.o.b. (name of officer)

I am giving this statement freely, having received no threats or promises to do so.

SEE STATEMENT ATTACHED

False statements made herein are punishable as a class "A" misdemeanor pursuant to Section 210.45 of the Penal Law

Signature of person giving statement

Diane LaMarco

Signature of person giving statement

Date 6/3/21

Sworn to before me

Witnessing Officer

Date

Notary Public

53-0176: 01/00cb

POLICE DEPARTMENT COUNTY OF SUFFOLK, N,Y. C.C.#_____
STATEMENT FORM
PDCS-1165b
Date 6/3/21 Time 9:39 AM
Page 1 of 2

I, **Thomas L LAMARCO of [redacted] PT JEFFERSON STATION, NY 11776 Lic #C-0[redacted]** (being duly sworn) deposes and says:
name
(words "being duly sworn" are to be crossed out if a sworn statement is not being prepared) that I am 59 years old.
(age)
I was born o[redacted] I am giving this statement to OFFICER PLIHCIK.
d.o.b. (name of officer)
I am giving this statement freely, having received no threats or promises to do so.

SEE STATEMENT ATTACHED.

False statements made herein are punishable as a class "A" misdemeanor pursuant to Section 210.45 of the Penal Law

Signature of person giving statement

Signature of person giving statement Date 6/3/21

Sworn to before me

Witnessing Officer

Date_____
Notary Public

53-0176: 01/00cb

Thomas and Diane LaMarco
[redacted]
Port Jefferson Station, New York 11776
631-[redacted]

May 27, 2021

To whom it may concern,

We live with our son [redacted] who is diagnosed with [redacted] He has been hospitalized a few times over the passed six years. [redacted] has not needed to be hospitalized during the last two years as the medications prescribed seem to be appropriate. He is compliant with taking his medication and has voiced the desire to never return to his previous state.

Prior to his illness and during it, we always kept our firearms in a closet that has a combination lock that locks automatically when closed, in a safe within that closet, and with a trigger lock at all times. We had called the police for assistance getting him to the hospital because he would not get in our car. While the police were here, an office asked if we had any firearms in the house, to which we replied we did and showed him where they were kept. He agreed that they were safely secured and not within our son's reach.

It is our desire to have our pistol licenses reinstated and our firearms returned as we believe they are safe within our home. We believe that our son is not a danger to himself or others. He has not expressed such thoughts and has never acted on such thoughts.

We have spoken with our son's therapist [redacted] LMHC, who has been seeing him for approximately two years and she expressed that he is doing well. She stated that it is Catholic Charities practice to not write a letter in support of firearms in the home as it opens them to liability, but she is willing to speak to whomever needs information regarding his current state. She can be reached at [redacted]

Cordially,

Diane LaMarco